

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9828

09836

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
37 TOWN <u>Chestertown</u>		Adult life		TOWN <u>Chestertown</u> 37			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Water St.</u>				<u>Water St.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
(First) <u>Mary</u>		(Middle) <u>J.</u>		(Last) <u>Archbell</u>		<u>Oct. 23, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>female</u>	<u>White</u>	<u>Widow</u>	<u>Jan. 16, 1865</u>	<u>90</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Virginia</u>		<u>USA</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Stephen Chester Roberts</u>				<u>Annie Harding</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>no</u>		<u>Wm. S. Collins</u> <u>Water St. Chestertown, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
782.4 IMMEDIATE CAUSE (A) <u>Heart failure</u>						3 days	
ANTECEDENT CAUSE (S) (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HDW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>50</u> to <u>10-23</u> , 1955, that I last saw the deceased alive on <u>10-22</u> , 1955, and that death occurred at <u>3: A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>no sick</u>				ADDRESS <u>M.D. Chestertown, Md.</u>		DATE SIGNED <u>10/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 24 1955</u>		<u>Chester Cemetery</u>		<u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 24-1955</u>		<u>Clara S. Barnes.</u>		<u>J. Willis Wells</u>		<u>Chestertown, Md.</u>	

BUREAU V. S.

OCT 30 1955

RECEIVED

9829

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>KENT.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Kent.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHESTERTOWN.</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHESTERTOWN</u>		<u>37</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent & Queen Anne's.</u>				STREET ADDRESS (If rural give location) <u>120 CANNON ST.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH: <u>OCT 9 1955</u>			
(First) (Middle) (Last) <u>FANNIE KENNARD BENJAMIN</u>							
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>OCT 6, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>KENT, Md.</u>	
13. FATHER'S NAME: <u>ALONZO KENNARD.</u>				14. MOTHER'S MAIDEN NAME: <u>CATHERINE BOONE.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS: <u>John E. Benjamin, Chestertown, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>170X</u> (A) <u>Metastatic Carcinoma of Liver.</u> DUE TO						<u>6 mos.</u>	
ANTECEDENT CAUSE (S) (B) <u>Primary Carcinoma of Breast.</u> DUE TO						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>9-28-55</u>				19B. MAJOR FINDINGS OF OPERATION <u>Metastatic Carcinoma of Liver</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9.25</u> , 19 <u>55</u> , to <u>10.9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10.9</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Arthur J. Barnes</u>				ADDRESS <u>Chestertown, Md.</u>		DATE SIGNED <u>10.9.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 10-1955</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09838

9836 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Kent</u>	
CITY OR TOWN <u>Galena</u>		LENGTH OF STAY (In this place)		CITY OR TOWN <u>Galena</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u>		(Middle) <u>A.</u>		(Last) <u>Campbell</u>		(Month) <u>OCT 2</u> (Day) <u>30</u> (Year) <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 16. 1883</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amiore Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ireland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218 05 8219</u>		17. INFORMANT & ADDRESS <u>Elsie Campbell Galena Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of hepatic flexure of colon</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>55</u> , and that death occurred at <u>10 a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wallace Oberhan</u>				ADDRESS (Street, city, town, state) <u>Cecilton Md</u>		DATE SIGNED <u>Oct 31/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 2. 55</u>		NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery.</u>		LOCATION (City, town, or county) (State) <u>Galena Md.</u>	
24. REC'D BY REGISTRAR <u>10/31/55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth J. Mueford</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Ballantyne</u>		ADDRESS <u>Millington Md.</u>	

100-38

MARYLAND STATE DEPARTMENT OF HEALTH-CALIMORE 18

CERTIFICATE OF DEATH

98-8

Dec. 1955

1. NAME, SURNAME (PRINT OR TYPE)

NAME

DATE

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF VENDOR

17. SIGNATURE OF SELLER

18. SIGNATURE OF BUYER

19. SIGNATURE OF TRANSFEREE

20. SIGNATURE OF TRANSFEROR

21. SIGNATURE OF TRANSFEREE

22. SIGNATURE OF TRANSFEROR

23. SIGNATURE OF TRANSFEREE

24. SIGNATURE OF TRANSFEROR

25. SIGNATURE OF TRANSFEREE

26. SIGNATURE OF TRANSFEROR

27. SIGNATURE OF TRANSFEREE

28. SIGNATURE OF TRANSFEROR

29. SIGNATURE OF TRANSFEREE

30. SIGNATURE OF TRANSFEROR

31. SIGNATURE OF TRANSFEREE

32. SIGNATURE OF TRANSFEROR

33. SIGNATURE OF TRANSFEREE

34. SIGNATURE OF TRANSFEROR

35. SIGNATURE OF TRANSFEREE

1. NAME, SURNAME (PRINT OR TYPE)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF VENDOR

17. SIGNATURE OF SELLER

18. SIGNATURE OF BUYER

19. SIGNATURE OF TRANSFEREE

20. SIGNATURE OF TRANSFEROR

21. SIGNATURE OF TRANSFEREE

22. SIGNATURE OF TRANSFEROR

23. SIGNATURE OF TRANSFEREE

24. SIGNATURE OF TRANSFEROR

25. SIGNATURE OF TRANSFEREE

26. SIGNATURE OF TRANSFEROR

27. SIGNATURE OF TRANSFEREE

28. SIGNATURE OF TRANSFEROR

29. SIGNATURE OF TRANSFEREE

30. SIGNATURE OF TRANSFEROR

31. SIGNATURE OF TRANSFEREE

32. SIGNATURE OF TRANSFEROR

33. SIGNATURE OF TRANSFEREE

34. SIGNATURE OF TRANSFEROR

35. SIGNATURE OF TRANSFEREE

BUREAU V. 2

NOV 3 1955

RECEIVED

9830

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

COUNTY

Kent

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

37 TOWN Chestertown

LENGTH OF STAY (in this place)

20 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

72 Kent and Queen Anns

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Queen Anns

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Pora - Church Hill

STREET ADDRESS

(If rural give location)

South East Farm 17X-9

3. NAME OF DECEASED: (Type or Print)

DECEASED

DECEASED

DECEASED

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

12-4-'82

9. AGE last birthday

72 yrs.

4. DATE (Month) (Day) (Year)

OF DEATH: October 31 1955

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Executive

10B. KIND OF BUSINESS OR INDUSTRY:

Automotive industry

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Harvey Coale

14. MOTHER'S MAIDEN NAME:

Laura Colman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

570.5

IMMEDIATE CAUSE

(A) Massive coronary occlusion

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

20 min

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

CARCINOMA of rectum

8 months

19A. DATE OF OPERATION:

10-13-55

19B. MAJOR FINDINGS OF OPERATION

Intestinal obstruction

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW, DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1, 1952, to 10-31, 1955, that I last saw the deceased

alive on 10-30, 1955, and that death occurred at 3:05 AM, from the causes and on the date stated above.

SIGNATURE

DeBick

ADDRESS

M.D. Chestertown, Md.

DATE SIGNED

10-31-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Nov. 2, 1955

NAME OF CEMETERY OR CREMATORY

Old St Pauls

LOCATION (City, town, or county) (State)

Fairlee Maryland

DATE REC'D BY LOCAL REGISTRAR

Nov. 1-1955

REGISTRAR'S SIGNATURE

Clara S. Barnes

24. FUNERAL DIRECTOR

Barton Biers

ADDRESS

Centerville Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 3 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9837

CERTIFICATE OF DEATH

09840

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		OR TOWN		OR TOWN	
X TOWN <u>Rock Hall</u>				<u>Piney Neck-Rock Hall</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rock Hall</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>Maurice P. Edwards</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31/55</u> 19 <u>55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH <u>March 3, 1885</u>	
				9. AGE last birthday <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector (retired) Tidewater Fisheries</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Chambers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-20-0439</u>		17. INFORMANT & ADDRESS <u>Mrs. Maurice P. Edwards-Rock Hall</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension, Cardiovascular</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 20</u> , 19 <u>55</u> , to <u>Oct 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Norbert K. Kitch</u>				DATE SIGNED <u>Rock Hall, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemetery Rock Hall, Maryland</u>			
DATE THEREOF <u>Nov. 2, 1955</u>				LOCATION (City, town, or county) (State)			
24. REC'D BY REGISTRAR <u>Belwood Burgess</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>			
REGISTRAR'S SIGNATURE				ADDRESS			
DATE <u>Nov 1</u>							

THE

38 11-500

04-22-90

[Faint handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9831

CERTIFICATE OF DEATH

Reg. Dist. No. 09841

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent & Queen Anne Hosp.</u>				STREET ADDRESS (If rural give location) <u>Worton P. D.</u>		1	
3. NAME OF DECEASED: (Type or Print) (First) <u>Calvin</u> (Middle) <u>Freeman</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 1</u> 19 <u>55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>March 24, 1955</u>	9. AGE last birthday (If under 1 year) (If under 24 hrs.)		yrs. <u>6</u> Months <u>7</u> Days <u>7</u> Hours <u></u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Bethesda Kent G. Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Rayford Freeman</u>				14. MOTHER'S MAIDEN NAME: <u>Ester Hyman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Wm. Rayford Freeman Worton Ind.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Infantile diarrhea</u>		<u>5 days</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 2, 1955</u> , to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>55</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.					
SIGNATURE <u>Willard F. Smith</u>		M. D. <u>Rock Hall</u>		DATE SIGNED <u>10/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>	
				LOCATION (City, town, or county) (State) <u>Bethesda - near Worton Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 3 - 1955</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR ADDRESS <u>Marvin V. Williams - Bethesda Ind.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 5 1955

RECEIVED

MARYLAND

9832

09842

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Chestertown (Rural)</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent and Green Aves</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>Earle</u> (Last) <u>Nicholson</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 18, 1881</u> 9. AGE last birthday <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Sara Husby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hosp. Records</u>			
15. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
410 X Immediate cause (a) <u>Myocardial failure, probably of old rheumatic fever origin</u>		<u>5 days</u>	
Antecedent cause(s) (b) <u>Myocarditis, mitral stenosis, annular fibillation</u>		<u>Many years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis in a small speckled cerebral thromboses</u>		<u>1 year</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture right femur</u>		<u>14 days</u>	
19a. DATE OF OPERATION <u>10-5-55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture upper 1/3 of femur</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>--</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>--</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>9-3</u> , 19 <u>54</u> , to <u>10-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-18</u> , 19 <u>55</u> , and that death occurred at <u>9:20 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Al Dick</u>		ADDRESS <u>Chestertown, Md.</u> DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>10/20/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>	LOCATION (City, town, or county) (State) <u>Kent Co. Maryland</u>
DATE REC'D BY LOCAL REG. <u>Oct. 19-1955</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

OCT 21 1955

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9838

CERTIFICATE OF DEATH

09843

Reg. Dist. No. 201

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>KENT</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>KENT</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>RURAL WORTON</u>	<u>LIFE</u>	TOWN <u>RURAL WORTON</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00			1
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>JOHN FLETCHER OAKLEY</u>		<u>OCT. 28, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>C</u>	<u>MARRIED</u>	<u>JAN. 1, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>LABORER</u>		<u>FARMING</u>	<u>MARYLAND</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>LEWIS OAKLEY</u>		<u>ANNA BECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>UNKNOWN</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>GERTRUDE OAKLEY WORTON, MD.</u>		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>	
		ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 27, 1955</u> , to <u>Oct 28, 1955</u> , that I last saw the deceased alive on <u>Oct 28, 1955</u> , and that death occurred at <u>9:30 P.</u> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Florence Bernig Jones</u>		<u>Worton, Md 10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>BURIAL</u>		<u>OCT. 31, 1955</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
		<u>Edmund Jones</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>B.R. Fellows</u>		<u>STILL POND, MD.</u>	
DATE			
<u>10/29/55</u>			

CERTIFICATE OF DEATH

8238

03513

DECEASED

RURAL WORTON

DECEASED

RURAL WORTON

JOHN FLETCHER OAKLEY
 MALE C
 LABORER
 FARMING
 MARYLAND
 U.S.A.
 WEDDED JAN 1, 1889
 OCT 28 82
 ANNA BECKER
 FLETCHER OAKLEY

UNKNOWN
 GERTUDE OAKLEY
 WORTON MD.

*General knowledge
 sufficient*

LEWIS A. B.

OCT 28 22
 OCT 27 22
 OCT 26 22

BURIAL
 OCT 31 1955 MT OLIVET CEMETERY
 WORTON MD
 A. A. FLETCHER
 1955

9833

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>KENT.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>KENT.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MILLINGTON</u> <u>X</u>	
<u>37</u> TOWN <u>CHESTERTOWN</u>	<u>2 wks.</u>	STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent & Queen Anne's Hosp.</u>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>BERTHA</u>	(Middle)	(Last) <u>ROBINSON</u>	OF DEATH: <u>OCT 14</u> 19 <u>55</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JUL 9, 1900</u>
9. AGE last birthday: <u>55</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>WILLIAM JARMAN</u>		14. MOTHER'S MAIDEN NAME: <u>MARY THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>HOSPITAL CHART.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>CEREBRO-VASCULAR ACCIDENT</u>		<u>1 day.</u>
ANTECEDENT CAUSE (S) (B) <u>HYPERTENSION</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>OP. CHOLECYSTO-DUODENAL FISTULA, EXPL. GASTROTOMY.</u>	
--	--

19A. DATE OF OPERATION: <u>10.10.55.</u>	19B. MAJOR FINDINGS OF OPERATION: <u>CHRONIC CHOLECYSTO-DUODENAL FISTULA with Bleeding.</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10.1.55, 1955, to 10.14, 1955, that I last saw the deceased alive on 10.14, 1955, and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE <u>Arthur J. Barnes</u>	ADDRESS <u>CHESTERTOWN MD.</u>	DATE SIGNED <u>10.14.55.</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct. 12, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Millington Cem.</u>
LOCATION (City, town, or county) (State) <u>Millington Md.</u>	DATE REC'D BY LOCAL REGISTRAR <u>Oct. 15-1955</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>
24. FUNERAL DIRECTOR <u>Edward Fellows</u>	ADDRESS <u>Millington, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 17 1955

RECEIVED

MARYLAND

9834

09845

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37</u> <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>37</u> <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>329 High St.</u>		STREET ADDRESS (If rural, give location) <u>1</u> <u>329 High St.</u>	
3. NAME OF DECEASED (First) <u>Arlington</u> (Middle) <u>Lee</u> (Last) <u>Sparks</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 16 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Crumpler Ann Am Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmitt Sparks</u>		14. MOTHER'S MAIDEN NAME <u>Agneta I ??</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>??</u>	
17. INFORMANT AND ADDRESS <u>Mr. Irving Sparks - Balls, 18 Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Probably Coronary Thrombosis</u>			<u>none</u>
Antecedent cause(s) (b) <u>Coronary insufficiency</u>			<u>don't know</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Arterio-sclerosis</u>			<u>don't know</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/21</u> , 19 <u>55</u> , to <u>10/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>55</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Robert W. Farr, M.D.</u> (Degree or title)		DATE SIGNED <u>10/22/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>Oct. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Chester County</u> LOCATION (City, town, or county) <u>Chestertown, Md.</u> (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Oct. 24, 1955</u> <u>Clara L. Barnes</u>		24. FUNERAL DIRECTOR <u>Wm. V. Wilkin</u> ADDRESS <u>Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 2

OCT 26 1955

RECEIVED

MARYLAND

9839

CERTIFICATE OF DEATH

09846
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Worton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Worton</u>		STREET ADDRESS (If rural, give location) <u>Worton</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>W</u> (Middle) <u>SUTTON</u> (Last) <u>TARBUTTON</u>	4. DATE OF DEATH	(Month) <u>Oct.</u> (Day) <u>6</u> (Year) <u>1955</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 8, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Quaker Neck, Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME (Late) <u>Wm. J. Tarbutton</u>		14. MOTHER'S MAIDEN NAME (Late) <u>Amanda Sutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ida C. Loller, Chestertown, Md.</u>			

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterial hypertension10 yrs?

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7-5, 1955, to 10-6, 1955., that I last saw the deceased alive on 7-5, 1955., and that death occurred at 2:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Oct. 9/55</u>	<u>Chester Cemetery</u>	<u>Chestertown, Md.</u>	

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct. 9-1955 Clara A. Barnes Marvin V. Williams, Chestertown, Md.

MARGIN RESERVED FOR BINDING

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

BUREAU V. S.

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9835

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent county</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write TOWN and give nearest town) <u>37</u> <u>Chestertown</u>		LENGTH OF STAY (in this place) <u>6 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>for Chestertown</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72</u> <u>Kentd Queen Anne's</u>				STREET ADDRESS (If rural give location) <u>Broad Neck Box 305</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Roland</u> (Middle) <u>S.</u> (Last) <u>UNRUH.</u>				OF <u>Sept</u> <u>2</u> 19 <u>55</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Aug 16 1895</u>	
				9. AGE last birthday <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Phila; Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel Unruh</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Short</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>DONT KNOW</u>		17. INFORMANT & ADDRESS: <u>PORA E. UNRUH (wife)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X IMMEDIATE CAUSE (A) <u>RENAL FAILURE</u>						5 DAY	
ANTECEDENT CAUSE (B) <u>PYLOPHLEBITIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CA of Rectum & Bladder invasion & infection</u>						3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>6/25/53</u>		19B. MAJOR FINDINGS OF OPERATION <u>② Left Hydro pyonephrosis</u> <u>① Extensive CA of Rectum & Bladder involvement</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/20, 1955</u> , to <u>10/2, 1955</u> , that I last saw the deceased alive on <u>10/2</u> , 1955, and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas D. Solow</u>		ADDRESS <u>226 Washington Ave. Chestertown, Md</u>		DATE SIGNED <u>10/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/5/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 4-1955</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells - Chestertown, Md.</u>			

BUREAU V. S.

OCT 6 1955

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